Scholar Archive

5-1-2018

The "M" Word: Management of Malingering in Corrections Mental Healthcare DNP Quality Improvement Project Final Report

Marla Castello

Follow this and additional works at: https://digitalcommons.ohsu.edu/etd

The "M" Word: Management of Malingering in Corrections Mental Healthcare

DNP Quality Improvement Project Final Report

Marla Castello

Oregon Health & Science University

May 18, 2018

Abstract

Malingering of psychiatric symptoms is a challenging, time-consuming and not uncommon behavior that mental health professionals need to assess, identify and manage effectively. This is particularly true for mental healthcare providers working in correctional settings. A literature search on available psychological tests and screening tools to detect malingering is presented, as well as specialized assessment techniques and ethical and legal implications of their use. A proposed quality improvement project is also discussed, with emphasis on conducting a staff training and implementing the Miller Forensic Assessment of Symptoms Test (M-FAST) to improve detection of malingering and access to care for those with genuine mental health needs.

Introduction

Malingering is listed as a V-code in the Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-5) under "Other Conditions That May Be a Focus of Clinical Attention" and is defined as "The intentional production of false or grossly exaggerated physical or psychological symptoms, motivated by external incentives such as avoiding military duty, avoiding work, obtaining financial compensation, evading criminal prosecution, or obtaining drugs" (APA, 2013). As the term is used to describe purposeful deception, it carries many implications for subsequent treatment and interactions within the healthcare system and should not be used without due consideration. However, malingering is also a reality of working in healthcare and can be expected to occur when motivating factors are higher than risks of detection. In general evaluations, the prevalence of malingering is approximately eight percent (Miller, 2001). Prevalence estimates of feigned psychopathology in correctional settings are varied, from 19.5% of jail referrals for mental health services (Rogers, Bagby & Dickens, 1992), 37.5% of inmates in a corrections-based psychiatric hospital (Wang, et. al, 1997), 45-56% of jail inmates requesting psychological services (Norris & May, 1998) and as high as 66% in a study

of jail inmates receiving psychological services and referred for assessment of suspected

malingering (McDermott & Sokolov, 2009). The high rate of malingering in correctional settings

necessitates an in-depth understanding of this behavior by clinicians working in jails and prisons.

Portland's Multnomah County operates the largest jail system in Oregon, including the

maximum security Multnomah County Detention Center (MCDC) and the medium security

Multnomah County Inverness Jail (MCIJ). Most inmates are pre-sentencing and the average

length of stay is 12 days (MCSO Planning & Research Unit, 2017), although individuals with

mental illness experience longer and more frequent incarcerations (Radcliffe, 2017). It has been

estimated that nearly 40% of the jail population is diagnosed with mental illness (Corrections

Grand Jury, 2016). Estimates of malingered psychiatric illness within the county jails are not

known as there has been no formal measurement or management of this issue. However, there

are many anecdotal accounts to indicate that malingering is problematic at these facilities. For

instance, many inmates are aware that ziprasidone and lurasidone require administration with

food for optimal drug absorption and frequently request these medications by name in order to

obtain extra food. Housing is commonly manipulated by use of "suicide watch" or requesting a

"mental health hold" to prevent transfer to MCIJ's open-dorm setting.

As mental health diagnoses are largely reliant upon subjective reporting, malingering can be

difficult to detect. However, detection of malingering is critical given its high prevalence rates

and the resultant burden this places on the corrections healthcare system. While under-

identification of malingering can lead to inefficient use of limited resources, decreased access to

care for those with genuine mental health needs and unnecessary medicine-related risks, over-

applying the label sets up an antagonistic patient-provider relationship, inadvertently decreases

access to care for those who are mislabeled and increases risk of litigation. The purpose of this

project is to help psychiatric providers working with the corrections population to be able to effectively identify, manage and document malingering in order to avoid wasteful use of resources, legal consequences and ultimately, negative patient outcomes. In turn, this may also decrease provider burnout and job turnover in the challenging corrections environment.

Literature Review

An initial literature review was performed on Ovid Medline by combining the terms "malingering" and "psychiatry/forensic psychiatry," yielding 76 results. The search was limited to peer-reviewed, full text articles and research conducted in the United States. The "Find Similar" and "Find Citing Articles" features were used to further expand search results. The Journal of Correctional Health Care was also independently searched to focus on relevant literature specific to corrections. Google Scholar was searched for works by Philip Resnick, a forensic psychiatrist who is well-known for his expertise on malingering. Lastly, reputable educational websites and textbooks were also used for foundational information. The focus of this literature review will be on 1) psychological testing available for malingering and 2) interview tips for assessment of malingering. Attention will also be given to the ethical and legal implications of this topic as well as effective quality improvement practices.

Psychological Tests

There have been several psychological tests developed to help aid in the determination of malingering. Each has unique advantages and disadvantages based on the evaluator's setting and goals. A review and side-by-side comparison of the five main tests is provided in Table 1. The first and perhaps most widely used test to assess general psychopathology is the Minnesota Multiphasic Personality Inventory (MMPI) (McDermott, 2012). The Personality Assessment Inventory (PAI) is a 344-item self-report instrument which is similar to the MMPI in that it was

designed to assess general psychopathology, includes validity scales and is interpreted by a

trained professional (McDermott, 2012). The Structured Interview of Reported Symptoms

(SIRS) is considered the "gold standard" for detection of feigned psychiatric symptoms

(McDermott, 2012). It is a 172-item structured interview that takes 30-45 minutes to administer

and evaluates for atypical responses, including rare symptoms, an unusual combination of

symptoms, highly improbable or absurd symptoms and inconsistencies between reported and

observed symptoms. The Structured Inventory of Malingered Symptoms (SIMS) is a 75-item

true or false screening instrument that assesses both malingered psychopathology and

neuropsychological symptoms (general feigning presentation, psychosis, neurologic impairment,

amnestic disorders, low intelligence, affective disorders). The SIMS, as well as the M-FAST

(described below), have shown statistically significant discrimination between probable feigning

and honest groups in individuals undergoing evaluation for workers' compensation and personal

injury claims. Both the SIMS and M-FAST had high sensitivity and strong negative predictive

power when applied to psychiatric feigning (but were not effective for detection of

neurocognitive feigning) (Alwes, Clark, Berry & Granacher, 2008). However, higher false

positive rates were found with SIMS when used in clinical populations and in people who were

more symptomatic or demonstrated higher levels of distress (Edens, Otto & Dwyer, 1999).

The Miller Forensic Assessment of Symptoms Test (M-FAST) is 25-item structured

interview designed as a brief screening tool for the assessment of malingering. It takes 5-10

minutes to administer and 10 minutes to score. It does not require the ability to read and has been

validated across different ethnic groups, gender and populations, including the correctional

setting. The M-FAST yields scores relevant to seven strategies: unusual hallucinations, reported

versus observed, rare combinations, extreme symptomatology, negative image, unusual

symptoms course and suggestibility. It may be administered and interpreted by a "mental health clinician with formal training in diagnostic interviewing and forensic psychology or psychiatry" (Holly, 2001, p.6). Using a cutoff score of six in a correctional sample, the M-FAST has a sensitivity of 86% and specificity of 83% (Guy & Miller, 2004). However, at a cut-off score of 16, the M-FAST predicted a classification of feigning on the SIRS in 100% of examinees. A cut-off score of 19 corresponded to 100% of examinees classified as feigning on the SIRS-2. At the expense of sensitivity, specificity can be maximized by utilization of higher M-FAST cut-off scores to make more confident assertions (Glassmire, Tarescavage & Gottfried, 2016). It has been shown to be strongly related to one of the two detection dimensions (Spurious Presentation) within the SIRS, providing evidence of its construct validity (Vitacco, et al., 2008).

There are several psychological tests that can be utilized to aid in the detection of malingered psychopathology. While the MMPI, PAI and SIRS have been widely used by forensic evaluators, they are time-consuming and out of the scope of PMHNPs and psychiatrists whose primary role is corrections-based medication management. Brief screening tools such as the SIMS and M-FAST are more feasible options for the busy clinical environment where the purpose of testing would be to assist treatment planning rather than legal decision-making. The M-FAST may be the most viable option for jail-based mental health providers to adopt as it is quicker to administer than the SIMS, validated in correctional settings and across ethnic groups, does not require the ability to read and is closely aligned with the well-established SIRS. Still, it is imperative that any positive screen is followed up with a thorough evaluation of malingering, including administration of further testing, clinical interviews, behavioral observation and review of collateral information (Guy & Miller, 2004). It is critical to note that psychological tests cannot ascertain motive or intention behind an individual's test performance and so testing alone

cannot "prove" malingering (Drob, Meehan & Waxman, 2009). Screening tools and tests can serve as one piece of information that helps to clarify whether or not a client is experiencing genuine mental illness. Based on degree of certainty, this information can in turn be used to guide treatment decisions.

Table 1. *Psychological tests to assess feigning of psychiatric illness*

	MMPI-2	PAI	SIRS-2	SIMS	M-FAST
Administr-ation time	60-90 minutes	50-60 minutes	30-45 minutes	15 minutes	5-10 minutes
Number of questions	567 true-false items	344 self-report items	172-item structured interview	75-item true or false items	25-items
Format	Paper and pencil	Paper and pencil	Structured interview	Paper and pencil	Structured interview
Purpose	Assesses general psychopathology but also includes embedded validity scales in order to detect response bias	Assesses general psychopathology but also includes embedded validity scales in order to detect response bias	Assesses a broad range of strategies in the detection of feigning	Screens for malingered psychopathology and neuropsychological symptoms	Screens for malingered psychopathology

Interview Techniques

   A detailed symptom inquiry is necessary to determine if reported symptoms are genuine or feigned. Dr. Phillip Resnick (2007) recommends beginning with a broad inquiry, asking the client to share as much detail as possible about the onset and course of each symptom. After open-ended, non-leading questions that allow the client to speak with few interruptions, the interviewer can then inquire about specific details and examples, comparing responses to what is known about genuine symptoms. For instance, auditory hallucinations are typically intermittent

rather than continuous, visual hallucinations generally do not change if eyes are closed or open and delusions do not suddenly start or stop. However, due to the variability in the phenomenology of hallucinations, the cumulative number of atypical properties reported should be considered rather than weighing heavily on any one area of inquiry (McCarthy-Jones & Resnick, 2014). Following open-ended questions with forced-choice questions allows the interviewer to begin to collect data that supports or refutes the suspicion of feigning.

The interviewer should ask about rare or improbable symptoms in the context of standard diagnostic questioning. For example, a client reporting psychotic symptoms can be asked "Have you ever believed that automobiles were members of an organized religion?" or "When people talk to you, do you see the worlds they speak spelled out?" in between other usual questions. (Resnick, 2007). Clients who endorse such illegitimate symptoms offer interviewers evidence of feigning. However, endorsement of rare or improbable symptoms may also be due to high suggestibility, desire to please the interviewer or cognitive deficits. Findings must be considered in the context of other available data to avoid making a premature conclusion.

In addition to assessing for inconsistencies between genuine and reported symptom characteristics, clinicians should look for several other types of inconsistencies, including: internal (within the client's own report), external (between client report and observed symptoms), between client report and testing performance and observed symptoms in different settings (Resnick, 1999). Special attention should be given to thought process and negative symptoms as these are often overlooked in efforts to feign psychosis. Lastly, requests for particular medications should be reviewed critically and clinicians should have an understanding of the unique drug abuse and diversion risks in correctional practice.

The determination of malingering cannot be made by a clinician until an external incentive or motivation for feigning psychopathology is also identified. Pilkinton and Pilkinton (2014) identified the following reasons psychiatric illness may be malingered in correctional facilities: to delay proceedings, avoid prosecution, generate support for a plea of not guilty by reason of insanity (NGRI), improve living situation by changing housing units and obtain prescription medications for abuse or exchange. It is important to note that malingering is not solely an either/or phenomenon but can also be superimposed on current genuine symptoms through exaggeration. A history of genuine symptoms may also be used to portray active symptoms in the present, or vice versa. Indeed, those who have actually experienced mental illness may be more successful at deceiving the interviewer (Conroy & Kwartner, 2006). Malingering should be differentiated from unreliable reporting without deliberate intent to deceit and factitious disorder, where the incentive is an internal motivation to assume the sick role. In order to accurately identify malingering, careful assessment is needed not only of reported symptoms but of the motivation underlying the counterfeit presentation.

Rather than one single test, interview or response, all available data should be integrated when deciding where a client falls on the spectrum of response style. The correctional setting provides ample opportunity to obtain collateral evidence of malingering through observing clients' day-to-day behavior on the housing units, reviewing correctional records such as grievances and disciplinary infractions, reviewing mental health records from prior custodies, monitoring medication adherence and interviewing other staff who have contact with the client. If a determination of malingering has been made after thorough investigation, it may be appropriate to confront the client with the findings. Rather than directly accusing the client of lying, the interviewer should ask for clarification of inconsistencies. Conveying understanding of

the temptation to exaggerate or falsify symptoms for personal gain may decrease defensiveness and promote acknowledgment of malingering. The client should be given every opportunity to save face by using statements such as "You haven't told me the whole truth," instead of "You have been lying" (Knoll & Resnick, 2006). Confronting the malingerer requires consideration for safety, ensuring a correctional officer is nearby to intervene if needed. Lebourgeois (2007) summarizes the clarification process with the mnemonic "ABCs": "Avoid accusations of lying, Beware of counter-transference, Clarification not confrontation, Security measures."

Legal & Ethical Implications

Malingering is a controversial topic that can be daunting for clinicians to address given the consequences of making a wrong determination, including lawsuits alleging malpractice (Lebourgeois, 2007). The term is highly prejudicial and thus medical records with "malingering" documented often have less probative value as evidence in a trial (Conroy & Kwartner, 2006; Johnson 2017). In a criminal trial, the label can be used as part of character assassination, making the clinician part of the prosecution rather than a patient advocate. In a civil trial, the term can be used as evidence of clinician negligence. Johnson (2017) recommends avoidance of the label "malingering" in medical record documentation entirely to avoid litigation risks and coloring the perception of subsequent providers. Instead, she recommends use of the term "unreliable reporter" or other phrases which do not explicitly assume intentionality. An explanation of why the client's symptoms are unbelievable, and what the possible motives for feigning are, should be clearly stated. Qualifiers regarding the time-limited, context-specific and nuanced nature of malingering are also important to clarify. Providers in the correctional setting should be aware of how to mitigate legal risks through thorough assessment and careful documentation of findings.

There are several ethical concerns related to evaluating malingering, the foremost being the extent to which an evaluator has the obligation to inform a client about detection efforts. Persons undergoing forensic evaluation have the right to know the purpose of the assessment but informing the individual of the purpose of a test for malingering would likely invalidate the procedure (Conroy & Kwartner, 2006). Conroy & Kwartner (2006, p.6) states, "Each evaluator must determine the appropriate level of detail in which an evaluation or technique is explained." Another ethical concern is the incorrect assumption that malingering is a diagnosis. Malingering is a conscious decision made based on perceived costs and benefits of doing so during any given situation. It follows then that this behavior will be strongly affected by the clinician's attitude toward and interaction with the patient. Drob, Meehan & Waxman (2009) argue that a clinician's negative counter-transference and hypervigilance for threats to professional identity may create a hostile relationship and increase the likelihood that patients are dishonest and manipulative. Lastly, mental health diagnoses are multifaceted, continually evolving and rooted in social norms. If symptoms do not fit into a known diagnostic category, evaluators should consider medical etiologies, culture-specific presentations and emerging research before assuming feigned psychopathology. Providers must continually revisit their personal and professional ethics when administering a screening tool, conducting interviewing, deciding whether treatment is indicated and documenting malingering.

Taken as a whole, the literature supports and recommends careful efforts aimed at the detection of malingered psychiatric illness. Malingering is particularly problematic in the jail setting where mental health providers are tasked with large caseloads, high incentives to falsify symptoms and challenging, complex patients. Providing clinicians with more tools to evaluate symptom presentations and guide decision-making can ultimately improve patient outcomes. The

M-FAST is a validated screening tool that can be used along with detailed interview and collateral information to make a sound clinical judgment. A provider training aimed at the detection, management and documentation of malingering would ensure an organization-wide evidence-based and consistent approach.

Methods

Context

The aim of this quality improvement project is to improve detection of malingered psychiatric illness at MCDC and MCIJ with the goal of increasing access to care for those with genuine mental health needs and ensure the limited mental health resources available within the county jails are being appropriately utilized. Provider appointments are typically booked out four to ten weeks in advance at a minimum and psychotropic medications are one of the leading correctional health costs. There is no formal process in place related to malingering; establishing a consistent management approach to this specific problem may reduce unnecessary provider visits. Anticipated barriers to implementation include generating momentum in a large system that is slow to change, the financial sustainability of using a copyrighted screening tool and the legal and ethical concerns previously posed. Project facilitators include a collaborative and open-minded group of mental health providers, support of the health department's county attorney and the medical director.

Participants

The participants are mental health providers at MCDC or MCIJ whose primary role at the county's two jails is medication management. There a total of five mental health providers covering the two facilities, including three part-time or on-call Psychiatric Mental Health Nurse

Practitioners (PMHNPs), one permanent psychiatrist and one temporary psychiatrist in a forensic fellowship role. At the start of this project, four out of the five providers had been in their current positions for one year or less and there has historically been a high turnover rate.

Interventions

The intervention included 1) a mental health provider training and 2) the implementation of the M-FAST screening tool. The training consists of a one-hour voiceover PowerPoint presentation uploaded to the Corrections Health Google Drive which includes information on 1) interview techniques to assess various malingered presentations, 2) administration and interpretation of the M-FAST and 3) documentation and legal recommendations. An online presentation format was selected at the medical director's request. This format allows for providers to watch the training at any time and review it as needed. In a setting with such high turnover of providers, it also allows for sustainability of the project overtime. Physical copies of the M-FAST screening tool as well as additional resources and learning materials are in a binder located in a provider's office at MCDC.

Measures

Proposed measures include 1) the number of times the M-FAST is used by providers per week (outcome measure), 2) provider perceptions and beliefs (process measure) and 3) treatment and follow-up scheduling practices for those identified as malingering (balancing measure). Due to the M-FAST's copyright protection, it is not financially feasible to formally screen all patients for malingering. The screening tool should used judiciously as an additional data point after or alongside detailed symptom inquiry. However, the target goal for frequency of M-FAST was two to four administrations weekly per provider, assuming a malingering rate of 20% and a weekly caseload of 12-20 patients per provider weekly.

Data Collection

   Data was obtained through chart review of the electronic health record EPIC and the online

survey tool Survey Monkey. survey results. Chart reviews of clients who were administered the

M-FAST were performed to see how M-FAST results were documented and what the scheduling

and treatment practices were for those clients (schedule as usual, schedule less frequently or stop

scheduling; prescribe or don't prescribe). Mental health providers were asked to complete a brief

online survey prior to the initial training on malingering and one month after implementation of

the screening tool with all providers. The surveys include ten multiple-choice or free response

questions related to provider knowledge, practices and beliefs surrounding the topic of

malingering (see tables two and three).

Table 2. *Pre-implementation provider survey questions*

1) What is prevalence of malingered psychiatric illness in the jails?
2) How often do you label a client as malingering in your documentation?
3) How often do you suspect malingering in clinical encounters?
4) How confident are you in your abilities to detect malingering?
5) How confident are you in your abilities to manage malingering appropriately?
6) How do you currently assess for malingering?
7) What concerns do you have related to malingering, if any?
8) Overall, how prepared do you feel to address malingering in practice?
9) How often do you use screening tools in your practice? Please comment on which tools you use and why or rationale for lack of use.
10) If a validated screening tool was implemented to assess for malingered mental illness, would the results influence your practice?

Table 3. *Post-implementation provider survey questions*

1) What is prevalence of malingered psychiatric illness in the jails?
2) How often do you label a client as malingering in your documentation?
3) How often do you suspect malingering in clinical encounters?
4) How confident are you in your abilities to detect malingering?
5) How confident are you in your abilities to manage malingering appropriately?
6) How do you currently assess for malingering?
7) Overall, how prepared do you feel to address malingering in practice?
8) Over the last month, what barriers did you face when using the M-FAST? Please select all that apply and comment on these barriers or others.
9) Please provide your feedback on the slideshow presentation and the M-FAST (i.e. what you learned, what you liked/disliked, what you would like to see more/less of, what works and what can be improved).
10) How likely is it that you will use the M-FAST screening tool in the future?

Results

The first iteration of the Plan-Do-Study-Act (PDSA) cycle took two weeks and focused on piloting the M-FAST with one provider. Over the course of two weeks, malingering was suspected in three patients and the M-FAST was administered, resulting in positive screens for all three. The scores and interpretation of scores were documented in the chart using phrases recommended in the literature. Despite positive screens, prescribing practices and follow-up scheduling practices were not significantly altered. This pilot implementation did not meet the goal of two to four administrations weekly however it was still felt to be a useful tool to have available. The goal was then reduced to a more attainable target of one administration weekly per provider. The second iteration of the PDSA cycle was initiated with all mental health providers and lasted five weeks. In that time, the M-FAST was only administered once.

The pre and post-implementation surveys provided insight into the lack of M-FAST use. On the pre-implementation survey, providers indicated that a validated screening tool to assess for

malingering would "probably" (66.67%) and "maybe" (33.33%) influence their practice. However, a variety of barriers to using the M-FAST were endorsed on the post-implementation survey: time constraints, lack of suspected malingering, and ethical, legal or professional concerns. The provider who noted lack of suspected malingering as a barrier also noted that she worked minimally during the implementation period due to change in position from part-time to on-call. The provider who used the M-FAST once endorsed no barriers and found it helpful despite not using it more frequently. The low use of the M-FAST may also be in part due to continued lack of knowledge of prevalence rates of malingered psychiatric illness in the jail setting. All providers underestimated the prevalence to be less than 20% on pre-survey and only one provider correctly reported a prevalence higher than 20% on the post-survey. Despite presenting prevalence information in the provider training, it appears this may be an area that requires further learning. Additionally, providers surveyed were already somewhat confident (33.33%) and mostly confident (66.67%) in their abilities to detect malingering pre-implementation, making it less likely that they perceived a need to implement the M-FAST. One provider did shift from "mostly confident" to "confident" in her detection abilities after implementation; the others remained unchanged. Although overall M-FAST administration was minimal, providers reported they would "definitely" (66.67%) and "maybe" (33.33%) use the screening tool in the future.

   Due to low use of the screening tool, data on the balancing measure of treatment and scheduling practices was not available. The process measure of provider perceptions and beliefs did lend support for the project as a whole. In response to the survey question about abilities to manage malingering appropriately, providers were "mostly confident" (66.67%) and "somewhat confident" (33.33%) post-implementation as compared to "somewhat confident" (100%) pre-

implementation. Overall preparedness to address malingering in practice increased from

"somewhat prepared" (66.67%) and mostly prepared (33.33%) to somewhat prepared (33.33%),

mostly prepared (33.33%) and prepared (33.33%). In a free-response question on current

assessment practices, post-implementation answers included reference to the M-FAST and more

detailed strategies when compared to pre-implementation answers. In a free response question

inviting general feedback, providers were receptive to the training and perceived it to be helpful.

Comments from one provider included: "I learned a lot about documentation terms. I also

learned not to use the word malingering due to legal concerns." Another wrote: "I learned

different techniques to determine possible malingering (i.e. eliciting details and noting atypical

symptoms) as well as utilizing the M-FAST in clinical practice…The legal considerations

regarding 'labeling' a patient with malingering and the 'do's and don'ts" of clinical

documentation was quite useful, and critical information, especially in the correctional setting."

While improvement did not occur based on the outcome or balancing measure, process measure

data indicates that providers did learn to more critically approach malingered mental illness.

Discussion

The primary aim of this project, to increase accurate identification of malingered mental

illness, was not successfully met. Detection of malingering is a challenging issue to definitively

determine progress towards since it is a time-limited and context-dependent behavior, the jail

population is continuously in flux and there is no way to confirm correctness of determinations.

Nonetheless, it is a worthwhile endeavor given the potential positive impacts this can have

downstream, including efficient use of resources, avoidance of legal consequences, decreased

provider burnout and job turnover, reduced unnecessary medication-related risks, increased

access to care and ultimately, negative patient outcomes. The intervention period was only five

weeks; a longer time frame is recommended for future PDSA cycles on this topic to allow for a

larger pool of patients and thus more opportunities to suspect malingering, utilize the M-FAST

and promote familiarity with its use. Separate PDSA cycles for the training and M-FAST

administration may have also allowed for more feedback and improved participation. Further

exploration of the barriers and concerns providers have with using the M-FAST is needed. The

pre and post-implementation surveys showed support for the project overall and demonstrated

that providers did seem to learn strategies to address malingering from the training. These

improved assessment skills could translate into increased identification of malingered mental

illness, regardless of adoption of the M-FAST. Future iterations of this project may emphasize

interview techniques to achieve the aim, leaving the M-FAST screening tool as a secondary

measure. At nearly six dollars per interview booklet, financial feasibility of continuing to use the

M-FAST will also need to be discussed going forward. If subsequent iterations of the project

prove to be worthwhile, the training video and materials would be a beneficial addition to new-

hire orientation.

Summary

In the corrections setting, it serves mental health providers to have skillful ways of

approaching malingered mental illness. The M-FAST screening tool has the potential to be a

useful resource, along with interview strategies and collateral information. The M-FAST's use

was largely limited by a short intervention period and provider reservations. However, the

implemented training positively impacted provider's perceived competency and understanding of

malingering which is encouraging for future impact seen in practice.

References

Alwes, Y., Clark, J., Berry, D., & Granacher, R. (2008). Screening for feigning in a civil forensic

setting. *Journal of Clinical and Experimental Neuropsychology, 30*(2), 133-140.

American Psychiatric Association (2013). *Diagnostic and Statistical Manual of Mental Disorders, fifth

edition*.

Conroy, M., & Kwartner, P. (2006). Malingering. *Applied Psychology in Criminal Justice, 2*(3).

Corrections Grand Jury. (2016). *Corrections Grand Jury Report 2016*. Multnomah County. Retrieved

from http://mcda.us/wp-content/uploads/2017/01/please-click-here.pdf

Drob, S., Meehan, K., & Waxman, S (2009). Clinical and conceptual problems in the attribution of

malingering in forensic evaluations. *The Journal of the American Academy of Psychiatry and the

Law, 37*(1).

Edens, J., Otto, R, Dwyer, T. (1999). Utility of the Structured Inventory of Malingered Symptomatology

in Identifying Persons Motivated to Malinger Psychopathology. *Journal of the American

Academy of Psychiatry and the Law, 27*(3).

Glassmire, D., Tarescavage, A., & Gottfried,E. (2016). Likelihood of Obtaining Structured Interview of

Reported Symptoms (SIRS) and SIRS-2 Elevations Among Forensic Psychiatric Inpatients with

Screening Elevations on the Miller Forensic Assessment of Symptoms Test. *Psychological

Assessment, 28*(12).

Green, D. & Rosenfeld, B. Evaluating the gold standard: A review and meta-analysis of the structured

interview of reported symptoms. *Psychological Assessment, 23(1),* 95-107.

Guy, L., & Miller, H. (2004). Screening for malingered psychopathology in a correctional setting. *Criminal Justice and Behavior, 31*(6).

Hawes, S.W. & Boccaccini, M.T. (2009). Detection of overreporting of psychopathology on the Personality Assessment Inventory: A meta-analytic review. *Psychological Assessment, 21*, 112-124.

Iverson, G. (2006). Ethical issues associated with the assessment of exaggeration, poor effort, and malingering. *Applied Neuropsychology, 13*(2).

Johnson, D. (2017). Understanding the legal implications of the term "malingering" [Powerpoint slides]. Retrieved from http://www.ncchc.org/filebin/Conference/2017/MH17/Speaker_PPTs/302_Johnson_-_Understanding_the_Legal_Implications.pdf

Knoll, J. & Resnick, P. (2006). The detection of malingered post-traumatic stress disorder. *Psychiatric Clinics of North America, 29*.

Lebourgeois, H. (2007). *Malingering: Key Points in Assessment.* Psychiatric Times. Retrieved from http://www.psychiatrictimes.com/forensic-psychiatry/malingering-key-points-assessment

McCarthy-Jones, S., & Resnick, P. (2014). Listening to voices: The use of phenomenology to differentiate malingered from genuine auditory verbal hallucinations. *International Journal of Law and Psychiatry, 37*.

McDermott, B.E. & Sokolov, G. (2009). Malingering in a correctional setting: The use of the Structured Interview of Reported Symptoms in a jail sample. *Behavioral Sciences & the Law, 27*, 753-765.

McDermott, B.E. (2012). Psychological Testing and the Assessment of Malingering. *Psychiatric Clinics of North America, 35.*

McKee, J., Penn,J., & Koranek, A. (2014). Psychoactive medication misadventuring in correctional healthcare. *Journal of Correctional Health Care, 20*(3).

MCSO Planning and Research Unit. (2017). *Monthly Jail Report, April 2017.* Retrieved from http://www.mcso.us/profiles/pdf/jail_stats.pdf

Miller, H. (2001). *Miller Forensic Assessment of Symptoms Test Professional Manual.* Psychological Assessment Resources, Inc.

Norris, M. P. & May, M.C. (1998). Screening for malingering in a correctional setting. *Law and Human Behavior, 22*, 315-323.

PAR, Inc. (2017). *PAI.* Retrieved from https://www.parinc.com/Products/Pkey/287

PAR, Inc. (2017). *SIMS.* Retrieved from https://www.parinc.com/Products/Pkey/410

Pilkinton, P., & Pilkinton, J. (2014). Prescribing in prison: Minimizing psychotropic drug diversion in correctional practice. *Journal of Correctional Health Care, 20*(2).

Radcliffe, S. (2017). *A Merry Go Round that Never Stops: Mental Illness in the Multnomah County Detention Center.* Disability Rights Oregon. Retrieved from http://www.mcso.us/profiles/pdf/2017_dro_report.pdf

Rogers, R., Bagby, R. M., & Dickens, S.E. (1992). *Structured Interview of Reported Symptoms (SIRS) and professional manual.* Odessa, FL: Psychological Assessment Resources.

Vitacco, M., Jackson, R., Rogers, R., Neumann, C, Miller, H., & Gabel, J. (2008). Detection Strategies

for Malingering with the Miller Forensic Assessment of Symptoms Test. *Assessment, 15*(1), 97-

103.

Wang, E. W., Rogers, R., Giles, C. L., Diamond, P.M., Herrington-Wang, L.E., & Taylor, E.R. (1997).

A pilot study of the Personality Assessment Inventory (PAI) in corrections: Assessment of

malingering, suicide risk, and aggression in male inmates. *Behavioral Sciences and the Law, 15*,

469-482.

Widows, M., & Smith, G. (2007). *SIMS Interpretive Report*. Psychological Assessment Resources, Inc.

Retrieved from https://www.parinc.com/WebUploads/samplerpts/SIMS_Report.pdf